LOS ANGELES COUNTY
HIV PREVENTION PLANNING COMMITTEE (PPC)
A Select Committee of the Commission on HIV Health Services
600 South Commonwealth Avenue, 6th Floor•Los Angeles CA 90005-4001

MEETING SUMMARY
Tuesday January 7, 2003
1:00 p.m.-5:00 p.m.
St. Anne's Foundation Conference Room
155 North Occidental Boulevard-Los Angeles, CA

MEMBERS PRESENT		ABSENT
Mario Perez	Jeff Bailey	Tony Bustamante
Dean Goishi	Buddy Akin	Kelly Gilmore
Chi-Wai Au	Sergio Avina	Shawn Griffin
Diane Brown	Richard Browne	Vicky Ortega
Gordon Bunch	Edward Clarke	Keisha Paxton
Cesar Cadabes	Mark Etzel	Efrain Reyes
Edric Mendia	Veronica Morales	Gail Sanabria
Ricki Rosales	Vanessa Talamantes	Kellii Trombacco
Kathy Watt	Tom West	
Richard Zaldivar	Rodolfo Zamudio	
David Zucker		

STAFF PRESENT		
Elizabeth Escobedo	Gabriel Rodriguez	Darren Roberts
Delia Sandoval	Rene Seidel	

I. ROLL CALL - Roll call was conducted. A quorum was present.

II. COLLOQUIA PRESENTATION –
Kevin Heslin, Ph.D. presented on "Do Specialist Self-Referral Insurance Policies Improve Access to HIV-Expert Physicians?" It is a large sample of people living with HIV from around the United States.

The Presentation next month will be "A Cognitive-Behavioral Intervention to Reduce HIV Risks among Active Drug Users" by Fen Rhodes, Ph.D.

Dr. Heslin answered questions on his presentation. To obtain copies of his presentation contact Ky Coussey at (310) 794-0448.

III. APPROVAL OF AGENDA
The Committee approved the agenda with a modification. Number VI. "HIV Incidence and Prevalence Estimates by BRG was moved to Number VIII.

IV. APPROVAL OF MEETING SUMMARY
There was no Meeting summary for December 2002.

V. PUBLIC COMMENT

Kathy Watt was welcomed as a new PPC member.

VI. HIV Prevention Plan Update

The new Prevention Plan ad Hoc is a combination of Standards and Best Practices, Evaluation and the Operations sub-committees. Last month a Timeline outlining several tasks to be completed through the PPC and the Sub-committees to address the Plan was provided.

VII. BREAK

VIII. PRESENTATION: "HIV Incidence and Prevalence Estimates by BRG" by Douglas Frye

A follow-up to the December EPI presentation was provided. The December presentation was a reflection of information that has previously been provided to the Commission. The presentation today will follow the BRG model. The following is a brief overview of Dr. Frye's presentation.

Dr. Frye said that the reason handouts were not provided was because this presentation is about 90% complete. He said that he would like to review additional studies and documentation to modify the figures.

Methodology

The estimates of persons living with HIV/AIDS are based on the HARS data and multiple other sources. Estimate of new HIV infections are based on Alternative Test Site data because they are the most complete and best incident data that is available. Sources for the BRG population estimates in the County vary.

People living with HIV/AIDS:

A modified CDC method for estimating people with HIV was used. HIV reporting began in July 2003, however that data may not be available until a couple of years. The data that is available is from AIDS reports. The CDC has made some estimates based on states that do both HIV and AIDS reporting. A ratio is obtained for every person living with AIDS. That methodology was modified to better reflect the population in Los Angeles County. As of June 2002 there were 16,663 reported persons living with AIDS. For every person living with AIDS in Los Angeles County it was estimated that there are 1.6 persons living with non-HIV/AIDS and only three out of the 4 persons living with HIV non AIDS are aware of their status.

It is estimated that over 52,000 people are living with HIV or AIDS in Los Angeles County. In the category of People living with HIV/AIDS, MSMW was not broken down, because it was difficult to estimate what their HIV/AIDS prevalence would be.

ESTIMATES of PERSONS LIVING WITH HIV AIDS by BRG:

MSM = 66.6 %; MSM/IDU = 6%; Heterosexual male IDU = 7.1%; Female IDU = 2.9%; Women at Sexual Risk = 9.4%; Other = 7.9%. (Dr. Frye mentioned that the majority of the men in the other category are at heterosexual risk for HIV.

POPULATION SOURCES: MSM (includes) MSM/W and MSM/IDU: U.S. census, LA Health Survey, HARS, ATS, Ultimate Test Site Data, Gay Latino Men's Study, HIV EPI Young Men's Survey and San Francisco Report. Heterosexual Male IDU and Female IDU: Dr. Longshore of UCLA and ADPA. Women at Sexual Risk US Census, LA Health Survey.

POPULATION: MSM (Includes MSMW): 312,000; MSM/IDU: 27,000; Heterosexual Male IDU: 57,000; Female IDU: 46,000; Women at Sexual Risk: 1.14 million.

Q. Of those 2,000 estimated new infections, Transgender was a carve-out and are those numbers going to play a role on the whole number of estimated new infections?

A. Right. It is very difficult to arrive at the population of the transgender in Los Angeles. They are small numbers compared to the race ethnic numbers. But their high incidence can be seen.

Q. *In the estimated new infection column of 2,000 that is a good intention artifact rather than a real number. Maybe it bears in mind that we keep that mind. In an earlier slide you said 7.2% of the estimated new infections are in the "other" category but in the BRG slide those 150 people are disappeared and reallocated to categories that they are not in. This has been a controversial issue over time as it was when the BRGs were first established. What happens to Heterosexual men who are not IDUs? Do they contribute a significant proportion of the new infections such that they should be considered as a BRG when redefining this? The reason they were not included in the past is that the EPI estimated that it probably contributed less than 1%*

maybe less than ½ % to the total new infections. But perhaps that has changed and some data should be offered to let the PPC committee decide whether or not to consider that.

A. Dr. Frye responded that he did break down heterosexual male non-IDU as a BRG because the numbers were high (over 4% of the total) and this is new. He will revise the 2,000 numbers and redistribute the "other" 7.2%. He stated that the PPC might want to look at this group to see whether a whole segment of the epidemic is being missed.

A. Dr. Frye indicated that the numbers for Female IDUs came partly from ADPA and Dr. Longshore's study. The ADAP figures were used mostly for race ethnicity, because Dr. Longshore did not have those. Dr. Frye asked if anyone had any data that he could use to please let him know.

Q. A Statement was made that women seek treatment least of all. You said that when you are not sure of a number you can add in a certain percentage to account for what is not know, but what could be guesstimated. Could that be done for female IDU's?

A. Dr. Frye responded that he hoped there is a study that he can use, rather than guesstimating.

Q. Gordon Bunch asked if that was not because the rate was so low it was just 1% for Latina female IDUs?

A. It was a low rate. When you look at the drug abuse data again that may be an underestimate.

Q. *How old is Dr. Longshore's data?*

A. **The data is from the early 90s. However, the numbers were expanded just proportionally by population. They were increased about 7.4%, same as the increase in the population.**

Q. There is a need to see how the epidemic looks for the Latino population in other jurisdictions (Orange and San Diego Counties) to see how the numbers change from population to population. When looking at culture Latinos there is a lot of movement back and forth to different areas. Not necessarily crossing the border, but other parts of California. Are there any sub groups under the Latino category?

A. No. However, although it is such a huge group that may be one group in which that could be done. But some of the sources don't necessarily break them into these groups.

Q. Are we not saying that 7.2% of "other" is heterosexual men?

A. No.

Q. It could be about people not just admitting the risk factor?

A. Right some of the assumptions in completing these estimates are that some people are not admitting behaviors.

Q. Is the 7.2 % of " other" still up for interpretation?

A. Yes. That is heterosexual risk. It breaks down into blood transfusion, and women at no sexual risk. When identifying as MSM and MSMW, there is quite a variation of responses, even among men who have sex with men. A larger proportion of the black community will identify as heterosexual, among Latinos it is less, and among whites it is much less.

Q. SHAS data is based on people who have already been diagnosed with AIDS. Can that data shed some light as far as determining some of these estimates? Because some of the questions that are asked in the SHAS supplemental survey show a difference between the reported risk that somebody might share at initial assessment and then might be changed later during the more extensive SHAS interview.

A. SHAS data was looked at for the "No Identified Risk" (NIR) because there is a proportion of no identified risk. Unfortunately, there is no paper trail of NIR versus non-NIR in SHAS. SHAS was also looked at for racial distributions and bisexual, MSM, MSMW.

Q. *What were the data* sources that were used when doing these *estimates?*

A. **ATS, Drug treatment data, STD, HARS, US census, LA health Survey data and then some of the studies and some expert guestimates.**

Q. Since you are most familiar with the analysis would you agree that it is fair to say that the BRG model that was used is a reasonable start? Some data highlighted pronounced increases in communities of color particularly in African American and Latino. A modification may need to be made to account for some of the heterosexual males who are not identifying as IDU or MSM.

A. Dr. Frye responded yes with modification. He said that he thought this was an excellent model.

Q. *In reference to youth and age in young people, it seems that since almost all of that data has to come from estimates and not from AIDS figures, because almost by definition, it is hard to accept that calculation, estimate the current epidemic in young people with AIDS data. What do you think about our estimate? In the past it was 25%. I saw a billboard in the Silver Lake area that says "The majority of new infections are in people under 25." I was a little surprised at that being presented as fact in a big billboard. What is your comfort level with estimates for prevalence and incident?*

A. **Dr. Frye responded that for the Title I grant application for the Youth category they looked at more sources to get the estimates. Including States that did HIV reporting like Colorado. In Colorado the ratio among youth was about 8 to 1 between HIV and AIDS. The ratio changes radically within that group between**

young, middle, and older youth, up to age 23. When looking at HIV you are looking at 10 years earlier than you are for AIDS.

Mario Perez made the following remarks.

- It is important to reiterate that to the extent that ATS data is used to estimate new infections there will always be a limitation. If a person with true behavior risk for HIV infection does not disclose it, it is not reported it and subsequently never gets factored into the estimates.
- Three years ago there was a discussion that 4 out of 1400 (less than 1%) new infections were among males with no hint of injection drug use and no male to male sexual behavior reported. Another group discussed was Asian women who inject drugs. EPI data was not sufficient to sustain an allocation for either group.
- **Mr. Perez** asked if there was a reason that on one of the slides for female IDU despite the proportions of Latinas in the County the number of Latino IDUs that are expected to be infected was 4% which seemed low even in spite of the proportional differences compared to African American women.
- **Dr. Frye** responded that the percentage of female IDU among the Latinas was lower. It seemed that we might be missing somebody if we leave out the heterosexual risk male especially among the African American community.

A comment was made that what was presented today used the current BRG model but did not touch on the 4 set aside groups (Youth, Native Americans, Transgender, Prevention for Positives). Accepting the BRG model does not preclude the PPC from looking as set-asides.

Jeff Bailey recommended that the PPC take a more enhanced look at the transgender population. Because he thought there was a void in today's presentation. There has been some talk from the Transgender Task Force in the Community that this be elevated more than just as a carve out but an actual piece of the BRG model, because of the incident rate percentage to the population. Mr. Bailey recommended that the PPC look at what the 7.2% in the "other population is."

XI. SUB-COMMITTEE REPORTS

It was noted that other than the Youth Leadership, Joint Public Policy sub-committees and Retreat ad hoc, this may be the final month that specific committee reports are provided, because of the merging of the Evaluation, Standards and Best Practices, and Operations sub-committees into the Prevention Plan ad hoc committee.

- **Evaluation** – Diane Brown reported that the Evaluation and Standards and Best Practices sub-committees will meet to discuss utilizing the current Evaluation meeting schedule for the Needs Assessment work group meetings. They will also revise and update the meeting questions for the needs assessment process. They compiled about 7 questions, which will be presented at the next work group meeting. Those will be divided and given to members as a task.
- **Joint Public Policy**
  Mark Etzel reported that at the request of the PPC Executive sub-committee, a letter about the budget deficit was sent to Governor Davis and to various committee heads in the Senate and Assembly. The letter was included in the packet.

- **Standards & Best Practice**
  Buddy Akin reported that they have two working groups. One is working on the draft of the committee's recommendations. Another group is working on the informative research component, which is the local focus group information.

- **Youth Leadership**
  Sergio Avina reported they prepared a calendar of the next six months meetings. Abstract submitted by Chi Wai-Au and David Zucker were accepted for the Ryan White Youth Conference.

  A writing group was formed to work with Reach LA to help with the development of youth friendly condensed orientation materials, developed from the Community Planning Guidance and the HIV Prevention Plan.

- **Retreat Planning Ad Hoc**

Veronica Morales reported that the PPC Retreat would be held at the ***Hilton Garden Inn***, in Calabasas on May 1 and 2, 2003. Ms. Morales expressed concern about attendance to the Retreat, because of possible PPC members attending the CDC Conference, which is tentatively scheduled for the month of the PPC Retreat.

Mario Perez said there are about 8 persons from Los Angeles County who were recommended for participation. The CDC is going through some significant restructuring in the organization. For nearly 10 years the CDC has funded Health Departments and also Community Based Organizations directly. The CDC is currently deliberating the future of those directly funded awards and their structure. Los Angeles County historically has faired pretty well compared to the rest of the country. Currently there are 12 organizations funded directly by the CDC to deliver HIV prevention. It is important that Los Angeles is represented and be able to provide a perspective about the future of the directly funded community based organizations process. A Western Regional meeting was postponed from December to February. He commented that this is a priority not just for OAPP but also for CBOs.

The PPC co chairs will meet with the Retreat ad hoc committee to provide guidance.

CHHS Update
Vanessa Talamantes reported that at the last Executive sub-committee meeting they discussed the recommendation from the Membership Task Force (Strategic Planning Process) about the merging of the PPC and Commission. The PPC requested a meeting of both the Commission and PPC executive sub-committees to discuss this issue in detail. The results of the discussion will be brought back to both bodies.

IX. OAPP REPORT

State CPG
Dean Goishi reported the California Office of AIDS is accepting applications for the CPG. An application was given to each PPC member and anyone else who was interested. It is a 30-person committee. The commitment involves attending three two-day meetings throughout the year. The first meeting is held in Redondo Beach, the second in San Francisco, and the Third in San Diego. The due date for submitting the application is January 10, 2003. For further information contact Dean Goishi or Rene Seidel from OAPP or Chris Nelson at the telephone number listed on the application.

STD/HIV Integration: **Dean Goishi** reported that the integration meetings have continued between OAPP and STD departments on how to work together to integrate STD screening and HIV. Tiffany Horton who represents the HIV Counseling and Testing Task Force and the two PPC co-chairs have participated in the meetings.

USCA: September 18 – 21, 2003, New Orleans. Abstracts are due April 7, 2003.

National HIV Prevention Conference: July 27 – July 30, 2003, Atlanta. Abstracts are due on 1-22-03.

CPLS: March 12 to 15, 2003.
NMAC will be releasing their abstract selection announcements today. The announcements will go directly to the primary presenters.

Board Request
Mario Perez reported that about three months ago the Board requested that monthly expenditures by SPA be reported by each of the contractors. A memo from the Director of DHS, Thomas Garthwaite to the Board has been received outlining how to proceed. There was a proposal to have periodic updates and then a final year end report of expediters by contract, by SPA for each of the 400 contracts maintained by OAPP. About 315 contracts are from the Care Services Division and over 100 through the Prevention Services Division. Several upcoming events will occur over the next 90 days.

Meeting/Training
There will be a meeting with OAPP to articulate how to move forward with the request by the board, the information that will be listed in a monthly basis, and reports that will be collected quarterly and annually. **Mr. Perez** responded to a question that notifications should go out within the next two weeks. There will be training sometime in February. A determination will be made about whether to have a meeting by allocation methodology of by service category.

Letter
OAPP will send a letter to each contractor.

Policies and Procedures
Policies and Procedures will be shared with each of the contractors. There is an expectation to achieve an understanding of how resources are currently being invested across each of the 8 SPAs for Care and Prevention contracts.

Form Describing Methodology
There has been increased attention on how resources are allocated and invested. OAPP has developed a form that describes the methodology for each of the different service categories, that is used to identify prevention and care need based on a number of factors including, counseling and testing data, number of person living with HIV/AIDS, and respective SPA. This is one attempt to demonstrate to the Board that in fact the investment in each SPA is consistent with the impact and to develop a uniform reporting approach.

OAPP has a better understanding of the investments made in each SPA for care services, because of the separate schedules and budgets. However for Prevention Services about 53% are for services that occur in more than one SPA.

The Responsibility is now on Both OAPP and providers to on a monthly basis be able to differentiate and indicate the investments in each SPA. A guide for future program implementation will be shared with the Board. **Mr. Perez** indicated that this would be started prior to July 2003.

Community Planning Guidance and Cooperative Agreement Guidance
The CDC is near completion of both the "***Cooperative Agreement Guidance"*** for Health Departments who respond to the CDC's annual application for prevention resources and the ***"Community Planning Guidance***" (which describes how to conduct business for 65 prevention planning bodies including the PPC.) One of the new items in the "***Community Planning Guidance"*** is a set of indicators that have been developed by the CDC with the intent of ensuring that planning is consistent across the country and that it is community based, inclusive, representative, and that there is parity among its members.

XII. CO-CHAIRRS REPORT

Selection of Co-chair Alternate
UCHAPS (Urban Cohoalition on HIV/AIDS Prevention Services)
The Governmental and PPC co-Chairs attend a UCHAPS meeting on a quarterly basis. A request has been received from UCHAPS to select a co-chair alternate. PPC members were asked for volunteers.

Ms. Talamantes informed PPC members to keep in mind that soon a new co-chair would be selected. Jeff Bailey's term as co-chair expires in March 2003. PPC members were asked to consider the possibility of extending Mr. Bailey's term. The person selected as the alternate should be a person who is considering becoming the next community co-chair. Interested PPC members were asked to contact the co-chairs. It was stated that arrangements need to be made so that the alternate can attend the UCHAPS meeting in New York, in March.

Mario Perez went over some of the expectations of the UCHAPS participants. There will be six meetings, to refine the work of UCHAPS. Miami is considering being a part of UCHAPS. UCHAPS recently developed an urban agenda that describes the impact of HIV and the prevention needs of urban settings across the country. The document will be shared with congress. It is a piece that will substantiate efforts to advocate for increased resources in urban American to address the HIV epidemic. There will be meetings in Washington to meet with members of congress. There will be training to learn about advocacy, and the role that members play. Meetings will take place either before or after a national conference. There will be UCHAPS meetings at the CPLS, USCA, and National HIV Prevention Conference. UCHAPS has an action plan committee and much of their work is to organize and plan. Dean Goishi represents Los Angeles County in that committee. The spirit behind UCHAPS is to have both the Community Planning and the Health Department Representatives share the views of a jurisdiction. There is a rule that if either the Health Department or the Community Co-Chair is not present that jurisdiction cannot vote.

David Zucker was nominated. Mr. Zucker said that he was happy to accept the nomination of UCHAPS alternate, however he would have to do more thinking about the responsibilities of community co-chair.

Nominations will be accepted until the end of the month.

Jeff bailey said that according to the current Policies and Procedures he is eligible to continue as community co-chair until the end of March 2003. The new community co-chair would begin at the April meeting. At the last Executive sub-committee meeting there was discussion about how to move forward. Mr. Bailey expressed interest to stay on, as co-chair until the Plan is completed so that there is continuity in the planning process. **Mr. Bailey** asked the PPC members to consider his recommendation. If PPC members were in agreement a revision would need to be made to the policies and procedures. Otherwise he encouraged PPC members to start thinking about nominations for the next community co-chairs, which would need to take place in March.

Community Breakout Update:
Copies of the Community Breakout summary were not available. This item was tabled until next month.

XIII. HIV Prevention Plan Update
The HIV Prevention Plan update was tabled for next month.

XIV. VOTE ON BRG MODEL
Jeff Bailey commented that according to the Timeline developed for completing the Plan, today a recommendation would be made about moving forward with the type of model to utilize in the next Prevention Plan. Several PPC members had some questions, recommendations, or thoughts about some areas that are missing in today's presentation about some estimated new HIV infections among the current BRG. **Mr. Bailey** said that he felt that the PPC body could still continue utilizing the BRG model as opposed to a target population model.

Mr. Bailey clarified that the vote consisted in continuing to use the BRG model. The BRG model would include the current ones. However recommendations could be made to look at some of the suggestions presented today about who is the 7.2% in the "*other population*."

Mr. Bailey indicated that he made a recommendation about the possibility of elevating the transgender into the BRG model if there is supportive data. Prevention for positives cannot be a BRG because they are already HIV infected. There was also a recommendation to look at youth because currently youth are within a subset of each BRG. The PPC may need to look at the State's mandate of about 25% for youth, because currently there is a waiver.

In reference to the BRG model **Mario Perez** made several comments including:

- It is important to note that the BRB model is based on an ample amount of evidence to be able to quantify estimated new infections.
- For transgender and the American Indian group it is recognized that the impact is significant but it is very difficult to quantify.
- If something has changed dramatically in the last few years that suggest the ability to quantify the impact among transgender, then it would be prudent to see how it fits into the BRG model.
- For youth the estimates are 50% of new infections occur among people under 25. The PPC will need to look at how to fit that into the BRG model and how to allocate resources.
- The PPCs intent is to make sure that the resources are being invested with programs that are having the most impact.
- Is if there was this ample amount of evidence to suggest that there is another BRG out there that is not captured by the current BRG model then the PPC would need to have a serious deliberation about adding a new BRG. **Mr. Perez** said that he has not seen anything to suggest there is a new BRG that is not being captured. He said he felt comfortable endorsing the current BRG model.

There were several other comments made including:

- It was stated that Houston recently went to a BRG model. Because of limited resources and funding, the vast majority of planning bodies across the United States are switching to BRG models.
- Since the introduction of quality treatments, mother to child has no longer been an issue with regard to funding from this body and is not included in the BRG model.
- A suggestion was made to do more investigation on transgender, because the risk behaviors within that population are varied. In working with the transgender population there is reason to be surprised and somewhat shocked at the variety of sexual risk behavior within that group.

- The current BRG model does embrace a combination of BRGs and population.
- Accepting the current BRG model does not close the option of including the set-asides.
- The Needs Assessment process and other data may provide clear answers about what areas of the MSM Latino community are most impacted, whether they are immigrant or non immigrant, county of origin, etc.
- Endorsing the current BRG model does not preclude the PPC to acknowledge that there may be a need for a model that allows for something that does not fit into a BRG, but that the PPC recognizes as a priority in Los Angeles County.
- Accepting the current BRG model merely suggests that the PPC is going to move forward with the approach that the Six BRGs is the model to work from, recognizing that there may be some other areas that need to be examined.
- It was strongly recommended to continue with the BRG model as the framework to use and to allow for some flexibility within this framework to identify other groups that may need to be focused on.

MOTION: A motion was made, seconded and approved to move forward with the BRG model, with a friendly amendment to read a follows; "To adopt the BRG model as the framework to commence the needs assessment process."

XV. STATE OFFICE OF AIDS UPDATE

Jeff Bailey reiterated that when the State office of AIDS, the California CPG meets in Redondo Beach in April it is very important that Los Angeles is present at this meetings.

XVI. ANNOUNCEMENTS

- **Jeff Bailey** announced that recently there was a release in the paper about the Syphilis outbreak, and the ongoing outbreak in Los Angeles. It is really important to recognize that the PPC paid attention to the syphilis outbreak, even though the PPC is an HIV Prevention Planning body. Many OAPP service providers have integrated HIV and STD. He was interviewed by Fox news this morning on their national cable, because the syphilis outbreak is making news across the United Stated and the increase in numbers of gay men. It is important to note that the PPC has done a really good job on promoting testing and treatment. An incredible job has been accomplished at the County level of educating physicians to report these cases.
- **Mr. Bailey** explained that people from the media might ask questions about the syphilis numbers. A lot of it has to do with increased attention to getting the word out about getting people screened and tested and reporting these cases. It is a known fact that condoms are available throughout the city of West Hollywood.
- **Tom West** affirmed that another comment is that the city of West Hollywood has distributed over 500,000 condoms.
- A question was asked if in the coming months of debate over the budget, the PPC was going to do anything else besides the letter that were sent to the governor? **Jeff Bailey** responded the letter was in response to what the Governor may do for the encurrent year.
- A question was asked if the PPC is capable of organizing visits from the various community groups to the various legislative offices? **Mark Etzel** responded that the Joint Public Policy would be discussing how to develop an action plan at their meeting.
- **Buddy Akin** announced that the Power Program at APLA is putting together a cab community member that is going to feed into a future larger cab to inform all the program activities at APLA. Anyone interested was asked to contact him.
- **Jeff Bailey** suggested that being that there are 5 different PHIP programs and each of them may be requesting community advisory board members, it may be advantageous to convene one cap that my inform each of those providers that do prevention for positives. Because with all the new CPNs have advisory boards and we may be over extending some of the people in the positive community.
- **Gordon Bunch** announced he had several 12-month only new positions to fill. Anyone interested should contact him.

XVII. CLOSING ROLL CALL

Roll call was conducted.

XVIII. ADJOURNMENT

Kathy Watt adjourned the meting in memory of George Vargas and Sam Potter. George worked at AIDS Service Center for many years and Sam Potter worker at Cri Help.

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